EA-1
Revised 11/99

# APPLICATION FOR FOSTER CARE ELIGIBILITY/MEDICAID

☐ Application ☐ Redetermination

☐ IV-E/MA ☐ CWS/MA ☐ IV-E
☐ IV-E (out of state placement) ☐ IV-E MA (child from out of state receiving Montana Medicaid)

County: _____ TO: _____ (Eligibility Worker)
From: _____ (Placing worker)

**INSTRUCTIONS:**
**IV-E Eligibility:** All the information on this form must reflect the current situation of the child on the date the petition w as filed or the parental agreement was signed and the child's income and resources at redetermination. (See additional instructions under "Deprivation"). If a child is receiving benefits (FAIM, Medicaid or Food stamps) at the time of placement into foster care, use this form to apply for IV-E Eligibility and Medicaid. If the child was not receiving benefits at the time of placement into foster care, submit the FA-250 "Application for Assistance", which will include all household income and resources, in addition to this form.
**CWS Eligibility –** Complete all information for the month of placement as they pertain to the child only.

## INFORMATION ON CHILD IN FOSTER CARE

Child's Name _____ SSN _____ EIN _____
Citizen ☐ Yes ☐ No (If no, provide verification of alien status)
Placed with _____ Provider Number _____
Foster Care Address _____ Birth date _____
Is child in school? ☐ Yes ☐ No Grade level _____ Location of School _____
Entry: _____ Exit: _____ School Name: _____
Name of adult child was removed from: _____
Is this the specified caretaker relative? ☐ Yes ☐ No County of Financial Responsibility _____
Custodial parent child removed from: _____
Custodial parent's address: _____

## JUDICIAL DETERMINATION

Date initial petition was filed: _____
Has a court order been issued? ☐ Yes ☐ No

- Does court order contain specified language? ☐ Yes ☐ No
- Placing agency with custody of child _____
- If custody of child in not with DPHHS, does an agreement exist between DPHHS and placing worker? ☐ Yes ☐ No

Has parental agreement been signed? ☐ Yes To date: _____ From date: _____ ☐ No
Ha(s)ve either/both parents' rights been terminated? ☐ Yes (If yes complete information below) ☐ No
Date of Mother's _____ Date of Father's _____

## DEPRIVATION

**For initial determination:** Describe the child's deprivation of parental support on the date the petition was filed by using the codes listed below:
**For Redetermination:** Describe the deprivation currently in the home from which the child was removed.

Codes apply to birth or adoptive parents only (AB) Absent; (DE) Deceased; (IC) Incapacitated; (ND) No Deprivation; (UL) Unable to Locate; (UP) Unemployed.

Father's Name: _____ Deprivation Code: _____

Mother's Name: _____ Deprivation Code: _____

## CHILD'S RESOURCES

| Kind of Resource | Location | Amount |
|---|---|---|
| | | |
| | | |

## CHILD'S INCOME

Is the child employed? ☐ Yes ☐ No If yes….. ☐ Full time ☐ Part time
Name of Employer: _____
Rate of Pay: _____ Hours per month: _____
Is the child receiving unearned income (e.g. Social Security, SSI, Child Support, Etc?) ☐ Yes ☐ No

| Source of Income | Amount last month | Amount this month |
|---|---|---|
| | | |
| | | |

## THIRD PARTY LIABILITY

Is the child covered by **medical insurance**? ☐ Yes ☐ No
Name of Insurance Company: _____
Address of claims office: _____
Policy Holder's Name: _____ SSN: _____
Group Cert#: _____ Policy # _____ Date Issued: _____
Is the child covered by **life insurance**? ☐ Yes ☐ No
Name of Insurance Company: _____
Address: _____
Policy Number: _____
Face Value: _____ Cash Value: _____

## TO BE COMPLETED BY THE PLACING WORKER:

Foster care payment is being made? ☐ Yes ☐ No
Application for Assistance (FA-250) has been completed? ☐ Yes ☐ No
CSED referral or notification of change has been referred to the Office of Public Assistance? ☐ Yes ☐ No

As Placing Worker in charge of this case, I understand that it is my responsibility to assist the child's parent(s) or guardian in completing the Fa-250 if necessary. I further understand that I must report to the Eligibility Worker all facts concerning any income and resources received by the child and any changes in the child's circumstances, including termination from foster care. These changes must be reported within 10 days.

Placing Worker Signature: _____ Date: _____

## TO BE COMPLETED BY THE ELIGIBILITY WORKER:

PROGRAM: ☐ IV-E Eligibility ☐ IV-E MA ☐ CWS-MA

☐ **DENIED** Effective Date: _____
☐ **APPROVED** (initial) Effective: _____ to _____
☐ **APPROVED** (redet) Effective: _____ to _____

*If IV-E is determined but IV-E-MA is denied, please explain in comment section.
Comment: _____

☐ Copy of completed EA-1 sent to Placing Worker

Eligibility Worker Signature: _____ Date: _____